R590. Insurance, Administration. (Effective 8-22-02)

R590-131. Accident and Health Coordination of Benefits Rule.

R590-131-1. Authority.

This rule is adopted and promulgated pursuant to Subsection 31A-2-201(3)(a) and Section 31A-22-619.

R590-131-2. Purpose.

The purpose of this rule is to:

A. permit, but not require, plans to include a coordination of benefits, or COB, provision;

B. establish an order of priority in which plans pay their COB claims;

C. provide the authority for the orderly transfer of information needed to pay COB claims promptly;

D. reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to this rule, does not have to pay its benefits first;

E. reduce COB claims payment delays; and

F. make all contracts that contain a COB provision consistent with this rule.

R590-131-3. Definitions.

A. “Allowable Expense” means:

1. The amount on which a plan would base its benefit payment for covered services in the absence of any other coverage.

2. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

3. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

4. When COB is restricted in its use to a specific coverage in a contract, for example, major medical or dental, the definition of allowable expense must include the corresponding expenses or services to which COB applies.

B. "Birthday" refers only to month and day in a calendar year, not the year in which the person was born.

C. “Claim” means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

1. services (including supplies);
2. payment for all or a portion of the expenses incurred;
3. a combination of (1) and (2) above; or
4. an indemnification.

D. “Continuation Coverage” means coverage provided under right of continuation pursuant to the federal COBRA law or the state extension law. For the purposes of this rule, a person’s eligibility status will maintain the same classification under continuation coverage.

E. “Coordination of Benefits” or “COB” means the process of determining which of two or more accident and health insurance policies, or other policies specifically included in this rule, covering a loss or claim, will have the primary responsibility to pay the loss or claim, and also the manner and extent to which the other policies shall pay or contribute.

F. “Custodial Parent” means the parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation is the custodial parent.

G. “Hospital Indemnity Benefits” means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

H. “Noncomplying Plan” means a plan that is not subject to this Rule.

I. “Plan” means a form of coverage with which coordination is allowed. The definition of plan in the contract must state the types of coverage, which will be considered in applying the COB provision of that contract.

1. This rule uses the term plan. However, a contract may, instead, use "Program" or some other term.

2. Plan shall include:

a. individual, group, or HMO health insurance contracts providing hospital expense or medical surgical expense benefits, except those explicitly excluded under Subsection R590-131-3.I.3.;

b. group, group-type, and individual automobile "no-fault" medical payment contracts, after statutory PIP limit 31A-22-306 through 309; and

c. Medicare or other governmental benefits, except as provided in Subsection R590-131-3.I.3.f. below. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

3. Plan shall not include:

a. hospital indemnity coverage;

b. disability income protection coverage;

c. accident only coverage;

d. specified disease or specified accident coverage;

e. nursing home and long-term care coverage;

f. a state plan under Medicaid, and shall not include a law or plan when, by state or federal law, its benefits are in excess of those of any private insurance plan or other non-governmental plan; and

g. Medicare supplement policies.

J. “Primary Plan” means a plan whose benefits for a person's health care coverage must be determined first according to R590-131-4 B. A plan is a primary plan if either of the following conditions is true:

1. the plan has no order of benefit determination;

2. all plans which cover the person use the order of benefit determination provisions of this rule and under those requirements the plan determines its benefits first.

K. “Secondary Plan” means a plan, which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this rule decides the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the provisions of this rule, has its benefits determined before those of that secondary plan.

R590-131-4. Rules for Coordination of Benefits.

A. General Rules:

1. The primary plan must pay or provide its benefits as if the secondary plans or plan did not exist. A primary plan may not deny payment or a benefit on the grounds that a claim was not timely submitted if the claim was timely submitted to one or more secondary plans and was submitted to the primary plan within 36 months of the date of service. A plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits.

2. A secondary plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

B. Determining Order of Benefits. Each plan determines its order of benefits using the first of the following rules that apply:

1. The benefits of the plan, which covers the person as an employee, member or subscriber, that is, other than as a dependent, are determined before those of the plan which cover the person as a dependent.

2. Dependent Child/Parents Married or Living Together. The rules for the order of benefits for a dependent child when the parents are married or living together are as follows.

a. The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year.

b. If both parents have the same birthday, the benefits of the plan, which covered the parent longer, are determined before those of the plan which covered the other parent for a shorter period of time.

c. If the other plan, R590-131-3.I.2b, does not have the rule described in R590-131-4.B.1, .2 and .3, but instead has a rule based upon another order, and if, as a result, the coordinating plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

3. Dependent Child/ Parents Separated, Divorced or Not Living Together. If two or more plans cover a person as a dependent child of parents divorced, separated or not living together, benefits for the child are determined in the following order:

a. first, the plan of the custodial parent of the child;

b. then, the plan of the spouse of the custodial parent of the child;

c. the plan of the non-custodial parent; and

d. finally, the plan of spouse of the non-custodial parent.

i. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health insurance coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

ii. If the specific terms of a court decree state that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses or health insurance coverage of the child and the child's residency is split between the parents, the order of benefit determination rules outlined in Subsection R590-131-4 B.2. Dependent Child/Parents Married or Living Together shall apply. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or

provided before the entity has actual knowledge.

iii. If there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses, if any, is:

A. the plan of the custodial parent;

B. the plan of the spouse of the custodial parent;

C. the plan of the non-custodial parent; and then

D. the plan of the spouse of the non-custodial parent.

4. Active/Inactive Employee, Member or Subscriber. The benefits of a plan, which covers a person as an active employee, member, and subscriber, are determined before those of a plan, which cover that person as an inactive employee, member, or subscriber. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this provision is ignored.

5. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term.

a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

b. The start of a new plan does not include:

i. a change in the amount or scope of a plan's benefits;

ii. a change in the entity which pays, provides or administers the plan's benefits; or

iii. a change from one type of plan to another, such as, from a single employer plan to that of a multiple employer plan.

c. The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

R590-131-5. Procedure to be Followed by Secondary Plan.

A. When it is determined, pursuant to Section R590-131-4 that the plan is a secondary plan, benefits may be reduced as follows:

1. when one of the plans has contracted for discounted provider fees, the secondary plan may limit payment to any copayments and deductibles owed by the insured after payment by the primary plan; or

2. if none of the plans have contracted for discounted provider fees, the secondary plan may reduce its benefits so that total benefits paid or provided by all plans for a covered service are not more than the highest allowable expense of any of the plans for that service.

B. The secondary plan must calculate the amount of benefits it would normally pay in the absence of coordination, including the application of credits to any policy maximums, and apply the payable amount to unpaid covered charges owed by the insured member after benefits have been paid by the primary plan. This amount must include deductibles, coinsurance and copays left owing by the insured member. The secondary plan can use its own deductibles, coinsurance and copays to figure the amount it would have paid in the absence of coordination, and a secondary plan is not required to pay a higher amount than

what they would have paid in the absence of coordination. A secondary plan shall only apply its own deductibles, coinsurance and copays to the total allowable expenses, not to the amount left owing after payment by any primary plans. Insurers must coordinate with plans listed under Subsection R590-131.3.I.2.b. with the same provisions under Subsection R590-131.5.B.

C. Nothing in this rule is intended to require a secondary plan to make payment for any service that is not covered as a benefit by the secondary plan.

R590-131-6. Miscellaneous Provisions.

A. Reasonable Cash Value of Services. A secondary plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision may be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan, which provides benefits in the form of services.

B. Excess and Other Nonconforming Provisions.

1. No policy, or plan as defined by this rule, may contain a provision that its benefits are "excess" or "always secondary" to any other plan or policy.

2. A plan with order of benefit determination rules which comply with this rule, which is called a complying plan, may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this rule, which is called a noncomplying plan, on the following basis:

a. if the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis;

b. if the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, such payment shall be the limit of the complying plan's liability; and

c. if the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the noncomplying plan.

3. If the noncomplying plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to such difference.

a. In no event may the complying plan advance more than the complying plan would have paid had it been the primary plan, less any amount it previously paid.

b. In consideration of such advance, the complying plan shall be subrogated to all rights of the employee, subscriber, or member against the noncomplying plan.

C. Allowable Expense. A term such as "usual and customary," "usual and

prevailing," or "reasonable and customary," may be substituted for the term "necessary, reasonable and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

D. Subrogation. The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

E. Right To Receive and Release Needed Information. Certain facts are needed to apply these COB rules. An insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. An insurer need not tell, or get the consent of, any person to do this. To facilitate cooperation with insurers; guidelines for medical privacy issues are provided under U.A.R R590-206, and Title V of Gramm-Leach-Bliley Act of 1999. Each person claiming benefits under a plan shall give the insurer any facts it needs to pay the claim.

F. Facility of Payment. A payment made under another plan may include an amount, which should have been paid under the plan. If it does, the insurer may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under the plan. The insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery. If the amount of the payments made by an insurer is more than it should have paid under the provisions of this rule, it may recover the excess from one or more of the following:

1. The insurer may recover from:

a. The insured it has paid. However, reversals of payments made due to issues related to coordination of benefits are limited to a time period of 18 months from the date a payment is made unless the reversal is due to fraudulent acts, fraudulent statements, or material misrepresentation by the insured. It is the insurers responsibility to see that the proper adjustments between insurers and providers are made.

b. The non-contracted provider it has paid. It is the insurers responsibility to see that the proper adjustments between insurers and providers are made. However, reversals of payments made due to issues related to coordination of benefits are limited to a time period of 36 months from the date a payment is made unless the reversal is due to fraudulent acts, fraudulent statements, or material misrepresentation by the insured.

c. The contracted providers it has paid . Subject to 31A-26-301.6(15)(a)(ii), it is the insurers responsibility to see that the proper adjustments between insurers and providers are made.

2. The insurer may recover from insurance companies. or

3. The insurer may recover from other organizations.

H. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

I. A plan, whether primary or secondary, may not be required to pay a greater total benefit than would have been required had there been no other plan.

J. Exception to claim payment guidelines and timetables expressed under 31A-26-301.5(2)(b) and R590-192-7, for coordination of benefit claims are allowed by the secondary plan:

1. if the secondary plan has proof that they are the secondary plan; and

2. for only as long as a submitted claim is without an explanation of benefits from the primary plan.

R590-131-7. Penalties.

Any insurer, which fails to comply with the provisions of this rule, shall be subject to the forfeiture and penalty provisions of Section 31A-2-308.

R590-131-8. Separability.

If any provision of this rule or the application of it to any person is for any reason held to be invalid, the remainder of the rule and the application of any provision to other persons or circumstances shall not be affected.

R590-131-9. Existing Contracts.

The commissioner will begin enforcing the revised provisions of this rule 45 days from the rule's effective date.

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